United Nations A/AC.253/16/Add.16

General Assembly

Distr.: General
30 March 2000

Original: English

Preparatory Committee for the special session of the General Assembly entitled "World Summit for Social Development and beyond: achieving social development for all in a globalizing world"
Second session
New York, 3-14 April 2000
Agenda item 2
Preparations for the special session of the General Assembly entitled "World Summit for Social Development and beyond: achieving social development for all in a globalizing world"

Review reports and proposals for further action and initiatives submitted by organs and specialized agencies of the United Nations system and other concerned organizations

Note by the Secretary-General

Addendum

Contribution from the International Monetary Fund

1. The Preparatory Committee, in paragraph 22 of the annex to decision 1 on the role of the United Nations system,[1] adopted by the Preparatory Committee at its first session, invited the International Monetary Fund (IMF) and the World Bank to report on progress made and obstacles encountered in the integration of social development goals into structural adjustment programmes, with a view to presenting strategies to mitigate the negative effects of those programmes on social programmes and strengthening their social dimension, as well as to improving their positive impact, taking into account the need to enhance coordination with other United Nations organizations in that regard.

[1] See *Official Records of the General Assembly, Fifth-fourth Session, Supplement No. 45* (A/54/45 and Corr.1), chap. VI, sect. B.

00-37474 (E) 030400

2. The Secretary-General accordingly circulates herewith, for the information of the Preparatory Committee, the report prepared by IMF in response to that request.

3. The IMF report is being issued, as received, in the language of submission only.

INTERNATIONAL MONETARY FUND

Social Policy Issues in IMF-Supported Programs: Follow-Up on the 1995 World Summit for Social Development

Prepared by the Fiscal Affairs and Policy Development and Review Departments

(In consultation with other Departments)

Approved by Vito Tanzi and Jack Boorman

March 16, 2000

Contents Page

Summary 4

I. Evolution of the IMF's Social Policy Advice 6

II. Social Safety Nets 8

III. Public Spending on Education and Health Care 10

A. Overview 10
B. Spending on Education, Health Care, and Social Indicators 11

IV. Strengthening IMF's Contribution to Poverty Reduction 16

Text Table
1. Improvement in Social Indicators in Member Countries, 1985–97 15

Figures
1. Changes in Education and Health Care Spending in Selected Countries with IMF-Supported Programs, 1985–98 11
2. Spending Levels on Education and Health Care in Countries with IMF-Supported Programs, 1998 13
3. Allocation of Education and Health Care Spending in Countries with IMF-Supported Programs, 1995 14
4. Benefit Incidence of Public Spending on Education and Health Care in IMF-Supported Program Countries (mid-1990s) 16

Text Boxes
1. Public Spending on Education and Health Care in 11 ESAF Countries, 1990s 12
2. Bolivia: Progress on the Poverty Reduction Strategy (January 2000) 18
3. Mozambique: Progress on the Poverty Reduction Strategy (January 2000) 19
4. Uganda: Progress on the Poverty Reduction Strategy (January 2000) 20

SUMMARY

1. A key element in the IMF's mandate is to contribute to the promotion and maintenance of high levels of employment and real income of its members. To this end, the **IMF promotes high quality growth, which encompasses a wide range of elements, including social policy. Over the years, these efforts have been supported by declarations of the Interim Committee (recently renamed the International Monetary and Financial Committee) of the IMF, underpinned by guidelines to staff, and also by the emphasis placed by Fund management on the need for a social pillar in the reform of the international financial architecture.** In November 1999, the Enhanced Structural Adjustment Facility (ESAF) was replaced by the Poverty Reduction and Growth Facility (PRGF), which places the reduction of poverty as a key objective for IMF concessional lending to low-income countries.

2. **The incorporation of social policies into IMF-supported programs relies on collaboration with the World Bank and other institutions (e.g., the ILO, UNDP, and WHO) which provide valuable input in their areas of expertise on social policy issues. Beyond the existing collaboration arrangements with the UN system, the new PRGF will benefit from the strengthening of collaboration under the new poverty focussed approach.**

3. **Sound macroeconomic policies and growth-enhancing reforms are both pro-growth and pro-poor.** However, in the short run, some macroeconomic adjustments can adversely affect some poor and vulnerable groups, while at the same time benefiting other poor groups. IMF policy advice seeks in the first instance to minimize the adverse effects, but when some are inevitable to achieve the desired reforms, to mitigate these effects through compensating measures. IMF policy advice also aims to promote universal access to basic social services by providing for adequate public social expenditures.

4. The IMF works closely with the World Bank and regional development banks in providing policy advice and in the design of **social safety nets**. Social safety nets in IMF-supported programs have included new temporary measures, such as temporary subsidies and public works programs as well as existing arrangements adapted appropriately. In its advice, the IMF has been sensitive to important issues that influence the effectiveness of social safety nets. Weak administrative capacity has sometimes hampered targeting of benefits and limited the scope of social safety nets and hence, greater reliance was placed on programs that were self-targeting. Labor markets measures have sought to strike an appropriate balance between social protection and disincentive effects on labor supply. Although budgetary constraints inevitably limit the scope of social safety nets, program targets protect or increase needed spending on compensatory measures even when the fiscal situation is difficult (e.g., Indonesia, Korea, and Thailand).

5. **IMF-supported programs have sought—in collaboration with the World Bank and other international institutions—to promote universal access to basic social services.** To this end, IMF staff has tried to ensure the consistency of macroeconomic stabilization and public spending needs, and emphasized the efficiency and the targeting of spending. IMF-supported programs have increased public spending for basic social services in countries where this spending was low, supported high-quality expenditures in these sectors, and protected or sought real increases in these expenditures during adjustment periods when poor households might lack the ability to pay for basic social services. Through the appropriate provision of basic education at the primary and secondary levels, as well as the provision of basic health care, public spending has also contributed to reducing gender disparity. Overall, in IMF-supported programs, considerable progress has been made in increasing public spending; during 1985–98, public spending on education and health care on average increased both as a percent of GDP and in real per capita terms, and such spending in poorer countries with ESAF (now PRGF) supported programs outstripped that in other program countries.

6. **On average, the education and health care indicators in the OECD/UN/World Bank working set of core indicators for measuring social development improved in IMF-supported program countries.** However, there were some important exceptions and more needs to be done. Improvements in social indicators in ESAF and Heavily Indebted Poor Countries (HIPC) have not been commensurate with the spending increases. Improvements in gender-specific indicators have also been mixed: improvements in female literacy have been slow in ESAF and HIPCs, and while female enrollment at primary and secondary levels has grown faster than male enrollment, the gender gap is still wide.

7. **The new PRGF will address many of these issues by making poverty-reduction efforts a more explicit element of a renewed growth-oriented strategy.** Policies in PRGF will be cognizant of the need to enable the poor to participate in and contribute to the growth process. This will be achieved through the formulation by the authorities in each country of a poverty reduction strategy and poverty reduction strategy paper (PRSP) through a participatory approach, which is also intended to enhance country ownership and accountability. Poverty reduction strategies are to be prepared in consultation with domestic stakeholders, regional development banks, the UN, bilateral donors as well as the World Bank and the IMF. The IMF will rely on the World Bank and other institutions to advise the authorities in the design of most elements of poverty reduction strategies. Poverty reduction strategies will include gender-related issues, which can be both a cause and effect of poverty. Targets will include reducing gender disparity in primary and secondary education, reducing maternal mortality rates, and improving access to reproductive health services.

8. **Developing comprehensive poverty reduction strategies is a challenging agenda and will take time.** To ensure that in the meantime the IMF's ongoing support is not halted, but rather includes the new PRGF elements as quickly as possible, ongoing PRGF-supported programs will be based on interim PRSPs which will set out the agenda for the preparation of a more comprehensive PRSP in a participatory manner. Countries such as Bolivia, Mozambique, and Uganda have already made substantial progress on this front.

I. Evolution of the IMF's Social Policy Advice

9. A key element of the IMF's mandate, as laid out in the Articles of Agreement, is to contribute to the promotion and maintenance of high levels of employment and real income of its members. To this end, the IMF promotes conditions for high quality growth, which encompass a wide range of elements including sound macroeconomic policies and growth-enhancing structural reforms. **The IMF must also be sensitive to the social implications of its policy advice relying on the views, inter alia, of the World Bank.**

10. Macroeconomic stability, market-friendly structural reforms, and good governance are the crucial ingredients for **rapid sustainable economic growth, which is a prerequisite for enduring poverty reduction. But growth is not enough. Targeted policies—anti-poverty policies—that enable the poor to contribute to (and share in the benefits from) growth**, to increase their capabilities, and to reduce their vulnerabilities to risks **are vital complements**.

11. **Since the 1995 World Summit for Social Development in Copenhagen, the IMF has given increasing attention to ensuring that the social development goals, which were laid out in the Copenhagen Summit (which emphasize human resource development), have been integrated into IMF-supported programs as well as into IMF policy advice, with the help of the World Bank and other international institutions.**

12. The efforts to integrate social policy in the operations of the IMF have been **supported by the declarations of the Interim Committee (recently renamed the International Monetary and Financial Committee), underpinned by specific staff guidelines, and have been revisited recently by the Executive Board.** In September 1996, the Interim Committee stressed the need for a stronger approach to social sector policies in its Partnership for Sustainable Growth.[1] In 1997, guidelines were issued to IMF staff, for improving the monitoring of social expenditures and social indicators. In addition, the recommendations relating to social issues of the recent evaluations[2] of the IMF's concessional lending facility—the Enhanced Structural Adjustment Facility (ESAF)—are being incorporated into IMF lending policies. More recently, in the aftermath of the Asia crises, the need for a social pillar—with the World Bank playing a key role in its design—to be developed in the context of the reform of the international financial system, has been stressed by Fund Management.

---

[1] See "Partnership for Sustainable Global Growth," an Interim Committee Declaration, 1996, *IMF Survey*, October 14, page 327.

[2] See *External Evaluation of the ESAF: Report by a Group of Independent Experts*, IMF, 1998; and *The ESAF at Ten Years: Economic Adjustment and Reform in Low-Income Countries*, by Staff of the IMF, 1997. Both documents can be found via the Internet: http://www.imf.org. The latter is also available as *Economic Adjustment and Reform in Low-Income Countries*, Studies by the Staff of the International Monetary Fund, edited by Hugh Bredenkamp and Susan Schadler, 1999 (Washington: International Monetary Fund).

13. **The incorporation of social policy into IMF-supported programs relies on collaboration with the World Bank and other international institutions** that provide valuable inputs in their areas of expertise on social issues. The IMF and the World Bank each take the lead in areas of their traditional mandate and responsibility. Thus, the IMF takes the lead on macroeconomic policies; structural reforms in related areas such as exchange rate and tax policy; and issues related to fiscal management, budget execution, fiscal transparency, and tax and customs administration. The World Bank takes the lead in advising the authorities on poverty issues, including the undertaking of poverty assessments and their monitoring, the design of sectoral strategies, institution building, the provision of social safety nets, improving the effectiveness and poverty orientation of public expenditure and in other structural reforms such as privatization.

14. **The IMF has also collaborated on social and related issues with various UN agencies.** The IMF and the UNDP have collaborated in a number of countries and regions to strengthen governments' capacities to formulate and implement economic policies. In the area of labor market and related social policy reform, guidelines were issued in 1996 to IMF staff on collaboration with the ILO and to ILO staff on collaboration with the IMF. Pilot countries have also been chosen for enhanced IMF-ILO collaboration and interaction among staff of the two institutions has increased. In addition, in late 1998, an initiative was started to strengthen collaboration between the WHO and the IMF on health-related issues in low-income countries.

15. Recently, the IMF has reviewed social sector issues in the ESAF, the HIPC Initiative, and IMF-supported programs generally.[3] **Directors of the IMF's Executive Board[4] observed that sound macroeconomic policies, coupled with effective social and infrastructure spending, foster faster long-term growth.**[5] In light of these considerations, they observed that social safety nets and appropriately targeted productive social spending can provide critical support for the success of countries' adjustment and reform programs. IMF Directors underscored the importance of closely integrating social policy issues into IMF-supported programs. The need for the international community to improve developing countries' access to industrial country markets was stressed, together with the importance of good governance, transparency, and accountability for ensuring the effective use of public resources. In the context of poverty reduction, priority spending needs may extend beyond the social sector, for

---

[3] See *HIPC Initiative—Strengthening the Link Between Debt Relief and Poverty Reduction, August 26, 1999,* which is available via the Internet: http://www.imf.org/external/np/esafhipc/1999/index.htm; and Gupta and others, 2000, *Social Issues in IMF-Supported Programs,* IMF Occasional Paper No. 191 (Washington: International Monetary Fund).

[4] The Executive Board represents member countries in day-to-day decision making at the IMF.

[5] See: *Concluding Remarks by the Chairman, Review of Social Issues and Policies in IMF- Supported Programs; HIPC Initiative—Strengthening the Link Between Debt Relief and Poverty Reduction; and Transforming the ESAF Executive Board Meeting 99/102, September 13.1999,* available via the Internet: http://www.imf.org/external/np/esafhipc/1999/99123.htm.

example, rural infrastructure. Directors emphasized that, as regards social issues, the World Bank and other relevant international organizations have the primary mandate and expertise.

16. Subsequent to the review of social policy issues, **in November 1999, the ESAF was replaced by the Poverty Reduction and Growth Facility (PRGF), which now places the reduction of poverty as a key objective for IMF concessional lending to low-income countries.**[6] PRGF-supported programs (details in Section III) will be consistent with poverty reduction strategy papers (PRSPs) prepared by the borrowing countries in a participatory manner involving various stakeholders including civil society, MDBs, the UN, and bilateral donors.

17. **Sound macroeconomic policies and growth-enhancing structural reforms, which will continue to be an integral part of IMF-supported programs and of IMF policy advice, are both pro-growth and pro-poor.** Such policies are also critical for sustained growth, which is needed for reducing poverty on a continuous basis. Research has established that low fiscal deficits and price stability promotes growth, and that economic growth is the most significant single factor that contributes to poverty reduction. Structural reforms that aim at reducing product and labor market rigidities help reduce poverty by positive supply effects and also by improving the poor's access to resources. Reducing inflation to single-digit per annum levels also enhances income equality and benefits the poor. When needed reforms and policy measures are postponed or implemented in a disorderly fashion, the poor may suffer more, as delayed reforms imply that the poor could continue to be adversely affected by open or repressed inflation and insufficient access to scarce goods. The contribution of growth to poverty reduction is highlighted in Chapter 4 of the forthcoming *World Economic Outlook*, Spring 2000.

18. While measures needed for **macroeconomic adjustment and structural reform generally benefit the poor, some poor and vulnerable groups can be adversely affected in the short-run.** IMF-supported programs and policy advice in the first instance seek to minimize the adverse effects. But when some negative effects are inevitable to achieve the desired reforms, the provision of **social safety nets** can mitigate the adverse effects on the poor. Productive **social spending,** appropriately targeted, can also affect long-run growth and poverty reduction. The policy framework of the new PRGF, via the PRSP, will give greater prominence to these considerations. The next two sections of this paper focus on social safety nets and public spending, which are two important channels through which macroeconomic policies have a social impact.

II. Social Safety Nets

19. **Mitigating the short-run adverse effects of reform programs on poor groups through social safety nets has been an important aspect of the IMF's policy advice and**

[6] See *The Poverty Reduction and Growth Facility (PRGF)—Operational Issues, December 13, 1999* and *Poverty Reduction Strategy Papers—Operational Issues, December 10, 1999*, which are both, available via the Internet: http://www.imf.org/external/np/pdr/prsp/poverty2.htm.

program design. This task has taken on a variety of forms, depending on the expected adverse size of the social impact, and availability of existing social safety net arrangements. In more recent IMF-supported programs in low-income countries, higher priority has been given to securing social protection objectives and larger budget allocations for social safety nets have been sought.

20. **In countries where the authorities could foresee that reform measures would have a sizable adverse social impact, the policy mix and sequencing have aimed to take this impact into account within a sustainable macroeconomic framework.** For instance, IMF-supported programs have aimed to phase out subsidies for food and other items gradually, rather than at once (e.g., Indonesia, 1999–2000, and Jordan, 1994–1999). The adverse impact on some groups, however, cannot always be totally eliminated, even if an appropriate mixing and sequencing of policies is adopted and in these cases social safety nets are needed.

21. **The social safety nets in IMF-supported programs have included new temporary arrangements—such as temporary subsidies and public works programs—as well as adapting existing social protection instruments to the needs of target groups—such as pensions and other permanent social security programs.**[7] Over time, permanent social protection arrangements (e.g., pensions, unemployment insurance) also have been established in the context of reform programs. In doing so, public social safety nets in IMF-supported programs have sought not to displace the existing system of voluntary, private transfers or family-based safety nets (e.g., Indonesia).

22. **IMF staff has relied largely on the World Bank, and to some extent on the regional development banks, to take the lead in the design of social safety nets for IMF-supported programs.** For example, in Indonesia, a targeted rice subsidy and community-based public works programs, designed by the World Bank, were incorporated into the 1998 IMF-supported adjustment program. This was also the case for the public works programs financed by the Asian Development Bank and the World Bank in Thailand in 1998.

23. **The design of social safety nets in IMF-supported programs has been influenced, among other factors, by the availability of existing social policy instruments.** Transition economies in the early 1990s had a broad range of social instruments that were poorly targeted (e.g., Moldova and Ukraine). A wide range of benefits covered the bulk of the population, *including the nonpoor. Thus,* the principal aim of IMF-supported programs in these countries has been to make government spending—for instance, food subsidies—better targeted, rather than to create new instruments. In contrast, low-income developing countries generally have limited social policy instruments, and the effort there has been to create arrangements that could reach affected population groups (such as transitory subsidies for the urban poor in the CFA franc zone countries in the aftermath of the 1994 devaluation).

---

[7] See *Social Safety Nets: Issues and Recent Experiences,* edited by Ke-young Chu and Sanjeev Gupta, 1998, (Washington: International Monetary Fund).

24. **The weak administrative capacity in many countries has hampered the targeting of benefits, particularly on the basis of incomes.** This has meant a greater reliance on programs that have self-targeting features, such as public works with below-market wages (e.g., Indonesia, Malawi, Senegal, and Thailand); subsidies on commodities consumed by the poor (e.g., lower quality rice in Indonesia); and shielding of particular groups (pensioners, the unemployed, single mothers, and children).

25. **Financial constraints have limited the scope of social safety nets.** The need to redress macroeconomic imbalances has typically precluded increasing total public spending; thus, a reallocation within the existing budgetary envelope to better-targeted programs has been necessary (e.g., Brazil in 1999). For example, Indonesia, Korea, and Thailand raised spending on social protection programs to 5.2 percent of GDP in 1998/99, 2 percent of GDP in 1999, and 2 percent of GDP in 1998/99, respectively, from between ½ percent and 1 percent of GDP in each country before the crisis.

26. **Labor market incentives have been a key concern in the design of unemployment benefits.** The challenge has been to strike an appropriate balance between social protection and disincentive effects. This balance will differ among countries, depending on social preferences, norms, and other factors. This has been the case in Korea, where the broadening of the coverage of unemployment benefits to 70 percent of the labor force in early 1999 from about 30 percent in 1998 has sought to minimize disincentives on the labor market.

27. **Ideally, social policy instruments should be identified and put in place in a non-crisis environment.** Such efforts can speed the establishment of cost-effective safety nets if difficulties arise and reform measures need to be undertaken.

III. Public Spending on Education and Health Care

A. Overview

28. **IMF-supported programs, in conjunction with the World Bank and other international institutions, have sought to promote universal access to basic social services.** The size and quality of public social spending can affect long-run growth and poverty reduction. The relationship between public social spending, growth, and poverty reduction, however, is complex and dynamic, involving many other factors, including private spending on education and health care, and how efficiently these allocations are spent and how well they are targeted to the poor. Forging a consensus on a proper balance between macroeconomic stabilization and sound public spending through a participatory dialogue among the government, civil society, and the international community can be facilitated by establishing social and poverty reduction programs that are integrated into a sustainable medium-term budgetary framework.

29. However, program targets have sought to protect or increase needed spending on compensatory measures, even when the fiscal situation is difficult.

B. Spending on Education, Health Care, and Social Indicators

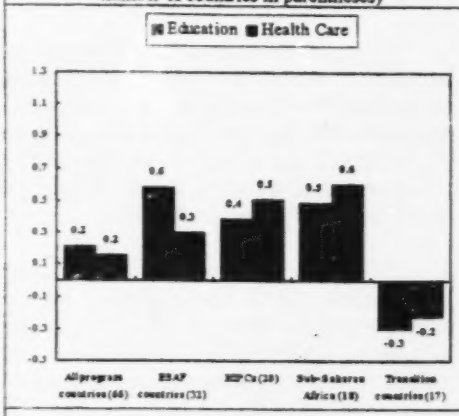
30. **ESAF-supported programs[8] have increased public spending for basic social services in countries where this spending was low, supported high-quality expenditure in these sectors, and protected or sought real increases in these expenditures during adjustment periods when poor households might lack the ability to pay for basic social services (Box 1).** The importance programs have attached to these objectives has been reflected in the rising use of quantitative targets and policy benchmarks aimed at raising education and health care spending.

31. **Overall, considerable progress was made in increasing social spending during 1985–98**. Although the lack of consistent data hinders the assessment of public social spending, program countries, on average, have achieved an increase in social spending:

- For 66 of the 107 countries with IMF-supported programs during 1985–98, government spending on education and health care, on average, has increased both as a percent of GDP and in real per capita terms (Figure 1).

- Higher social spending has in some cases been achieved through a reduction in military outlays. In a subset of 29 countries, of which 19 are ESAF countries that have data on military spending, such spending on average declined during 1990–97, whereas education and health care spending together increased in relation to both GDP and total government spending.

Figure 1. Changes in Education and Health Care Spending in Selected Countries With IMF-Supported Programs, 1985–98
(Average change between preprogram year and latest year in percent of GDP; number of countries in parentheses)



Sources: National authorities; and IMF staff estimates.

[8] This section refers to ESAF, rather than PRGF, programs because this was the loan facility in effect over the time covered by this analysis.

Box 1. Public Spending on Education and Health Care in 11 ESAF[1] Countries, 1990s

1. A detailed review of 11 countries with ESAF arrangements during the latter half of 1990s illustrates a range of approaches and success with public spending on education and health care.[2] In transition economies, where existing high and inefficient levels of education and health care spending tottered on a collapsing revenue base, IMF-supported programs emphasized quality and efficiency improvements. In nontransition countries, programs emphasized reorienting government expenditures to raise spending on education and health care, as in Bolivia, Lao People's Democratic Republic, and Uganda, where deficit and/or overall expenditure levels were programmed to rise as a share of GDP, in part to raise spending on education and health care. In addition, in some nontransition countries, program objectives for education and health care spending were also set in the context of longer-term goals drawn from the authorities' strategic plans for poverty reduction (e.g., Burkina Faso, Ghana, and Malawi). In recent years, these objectives have become more quantitative, particularly in HIPC countries that have reached the decision point (Bolivia, Burkina Faso, Côte d'Ivoire, Mozambique, and Uganda).

2. All of the programs reviewed included measures to improve fiscal governance, such as expenditure management, setting of budgetary spending allocations and priorities, expenditure controls, reporting, and transparency. In Mozambique, for example, reforms included the publication of budget plans and outcomes. Programs often focused on improving cost-effectiveness and spending composition by including measures to reduce hiring excessive number of teachers, improve the school curriculum, introduce second shifts in schools, reorient spending towards primary education and basic health care, and protect such spending during fiscal adjustment.

3. The scope of spending targets that could be monitored was constrained by lack of data on the intrasectoral allocation of education and health care spending, incomplete coverage of these sectors, and lags in the availability of data. Notwithstanding these challenges and given the complex link between spending and final outcomes, programs monitored actual spending and developments in intermediate social indicators such as the hiring or firing of teachers and consolidation of schools (Armenia), increasing water supply and number of classrooms created (Côte d'Ivoire), reducing stays in hospitals (the Kyrgyz Republic), and increasing the share of textbooks in the budget (Malawi).

4. A number of innovations have strengthened monitoring, including the introduction of explicit targets. In more recent ESAF-supported programs, formulating a clear framework in program documents that integrated social spending targets with a time path of specified indicators and outcomes, improved the focus and monitoring of social policy. In specifying public spending targets and policy measures and in monitoring, IMF staff collaborated with the World Bank and regional development banks.

5. Conditionality[3] was attached to public spending targets and to key reforms for which timely implementation was essential to the success of the program. However, conditionality was used sparingly and was designed to encourage the timely completion of sectoral and national poverty reduction strategies and action plans, which were prerequisites for establishing a clear operational strategy for improving access to social services over the medium-term.

---

[1] In late 1999 the ESAF was replaced with the new Poverty Reduction Growth Facility (PRGF).

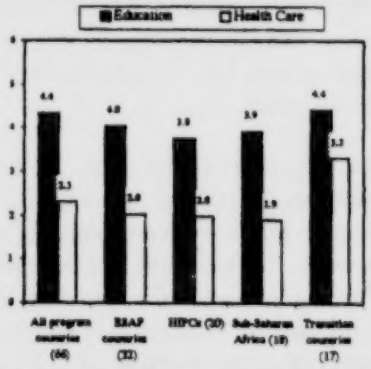
[2] These countries were selected to be representative of the group of ESAF countries and on the basis of data availability. They included Armenia, Bolivia, Burkina Faso, Côte d'Ivoire, Georgia, Ghana, the Kyrgyz Republic, Lao People's Democratic Republic, Malawi, Mozambique, and Uganda.

[3] Policy measures that members intend to follow as a condition for the use of IMF financial resources.

32. However, real per capita social spending has declined in some countries, and the increases have been relatively low in some regions, notably education spending in sub-Saharan Africa.[9] In transition economies, real per capita spending on education and health care has declined considerably. Partly reflecting a fall in GDP, there was a smaller decline in the share of such spending in GDP. In these countries, however, education and health care spending historically had been high and inefficient.

33. **Countries with ESAF-supported programs have shown relatively strong results.** In the 32 countries with ESAF-supported programs, the real per capita growth of spending on education and health care over 1985–98 (4.3 percent and 4.2 percent, respectively) has outstripped, on average, that in other program countries.

Figure 2. Spending Levels on Education and Health Care in Countries with IMF-Supported Programs, 1998
(In percent of GDP; number of countries in parentheses; latest year for which data are available 1/



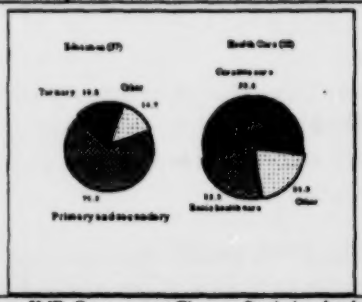
Sources: National authorities; and IMF staff estimates.
1/ Mostly 1998.

34. **In 1998, public expenditure on education and health care as a share of GDP in countries with ESAF programs approximated those in other program countries.** In HIPCs, spending levels remain below those in other program countries, in part, because of very low initial levels (Figure 2). Education and health care spending as a share of total government spending—indicative of the priority assigned to these types of spending—shows the same pattern.

35. **Although many programs have sought to improve the allocation of budget resources within the education and health care sectors, more needs to be done.** On average, program countries have devoted a relatively large share of their education budget to tertiary education and even a larger part of health care outlays to curative services (Figure 3). This suggests that low-income households would benefit from a shift in budgetary resources toward primary education and basic health care.

[9] Nevertheless, in many countries in Africa spending on social sectors increased under IMF-supported programs. Spending on education as a share of GDP increased in: Benin, Burkina Faso, Cameroon, the Comoros, Ethiopia, Kenya, Lesotho, São Tomé and Príncipe, Sierra Leone, Zambia and Zimbabwe. In health care, Benin, Burkina Faso, Cameroon, Cotê d'Ivoire, Ethiopia, Guinea-Bissau, Lesotho, Madagascar, Mali, Mozambique, Niger, São Tomé and Príncipe, and Sierra Leone experienced an increase in spending as percent of GDP. Real per capita spending on education increased in: Benin, Burkina Faso, Cameroon, Ethiopia, Lesotho, Mozambique, São Tomé and Príncipe, Sierra Leone and Zimbabwe. In health care, the countries where real per capita spending on health care increased are: Benin, Burkina Faso, Cameroon, Ethiopia, Lesotho, Madagascar, Mali, Mozambique, Niger, and São Tomé and Príncipe.

Figure 3. Allocation of Education and Health Care Spending in Countries with IMF-Supported Programs, 1995
(In percent of total education and health care spending; number of countries in parentheses; latest year for which data are available)[1,2]



Sources: IMF, Government Finance Statistics database; World Bank, *Public Expenditure Review and Poverty Assessment*, various issues; and IMF staff estimates.
1/ Mostly 1995.
2/ Shares may not sum to 100 percent because of variation in the sample reflecting unavailability of data for some countries.

36. **On average, the education and health care indicators in the OECD/UN/World Bank working set of core indicators for measuring social development have improved for program countries.** But there are important exceptions. In sub-Saharan Africa, average life expectancy has declined, reflecting the toll of HIV and conflicts (Table 1). Improvements in social indicators in ESAF countries and HIPCs have not been commensurate with the spending increases. Progress in improving infant mortality and primary and secondary enrollment has been slower in these countries than in other program countries. Transition economies have experienced declines in enrollment rates in secondary education and immunizations; reforms in these two areas have been slow, thus increasing the risk that the declines in spending may lead to a permanent setback in social indicators.

37. Data for 29 program countries show that the targeting of education and health care spending could be improved; particularly in sub-Saharan Africa and in the transition economies. For sub-Saharan Africa, 14 percent of total spending on public education and 12 percent of health care spending, on average, accrue to the poorest fifth (quintile) of households compared with 30 percent for the richest quintile for both. These gaps widen for spending on secondary and tertiary education and hospital care; spending on primary education is somewhat better targeted than that on secondary and tertiary education; and the targeting of public spending on education and health care is improving in some countries (e.g., Côte d'Ivoire and Malawi).

38. **Improvements in gender-specific indicators in program countries are also mixed.** Female literacy has on average increased at the same rate for both program and non-program countries, albeit at a lower rate in ESAF and HIPCs. Except for transition economies, female enrollment at primary and secondary levels has grown faster than male enrollment. However, the gender gap still remains.[10]

[10] Comparison of gross enrollment rate may understate the gender gap as compared with net enrollment rate since the former does not take into the account drop-out rate, which is likely to be higher for females than males.

Table 1. Improvement in Social Indicators in Member Countries, 1985-97
(Current level and average annual percent improvement; number of countries in parentheses)

	Current Level[1]			Average Annual Percent Improvement							
	Nonprogram Countries[2]	Program Countries	ESAF Program Countries Only	Nonprogram Countries[2]	Program Countries	ESAF Program Countries Only	HIPC Countries Only	Sub-Saharan Africa	Asia and the Pacific	Latin America and the Caribbean	Transition Economies
Education											
Illiteracy rate[3]	15.8 (22)	27.4 (49)	45.5 (21)	3.4 (22)	3.5 (49)	2.2 (21)	2.2 (16)	2.4 (15)	3.1 (8)	2.9 (14)	7.9 (7)
Female	18.6 (22)	32.8 (49)	53.4 (21)	3.6 (22)	3.5 (49)	2.1 (21)	2.0 (16)	2.3 (15)	3.1 (8)	3.0 (14)	8.3 (7)
Gross primary school enrollment rate[4]	104.2 (25)	92.3 (55)	80.9 (25)	0.1 (25)	0.8 (55)	1.0 (25)	0.9 (15)	0.6 (15)	0.5 (10)	0.7 (14)	1.0 (13)
Female	102.8 (25)	88.6 (52)	76.6 (24)	0.3 (25)	0.8 (52)	1.1 (24)	1.2 (14)	1.1 (14)	1.4 (9)	0.5 (13)	0.1 (13)
Male	105.8 (25)	96.5 (52)	84.0 (24)	0.1 (25)	0.7 (52)	0.9 (24)	1.4 (14)	1.0 (14)	0.0 (9)	0.6 (13)	0.8 (13)
Gross secondary school enrollment rate[4]	61.8 (25)	50.5 (53)	30.6 (24)	2.8 (25)	1.1 (53)	0.8 (24)	0.9 (14)	1.2 (14)	2.2 (10)	1.4 (14)	-0.8 (12)
Female	65.0 (24)	49.5 (49)	28.4 (23)	3.2 (24)	1.9 (49)	2.3 (23)	2.8 (13)	3.1 (14)	3.5 (10)	1.2 (10)	-0.5 (12)
Male	62.6 (24)	51.9 (49)	32.5 (23)	2.7 (24)	0.6 (49)	0.2 (23)	0.5 (13)	0.3 (14)	1.6 (10)	1.4 (10)	-0.9 (12)
Net primary school enrollment rate	84.8 (18)	74.6 (31)	58.9 (17)	0.2 (18)	0.7 (31)	0.6 (17)	0.5 (11)	0.1 (10)	0.9 (4)	0.9 (11)	0.4 (4)
Persistence to grade 5	88.5 (21)	75.3 (23)	68.0 (11)	0.5 (21)	1.7 (23)	2.0 (11)	2.9 (8)	2.3 (9)	-0.3 (5)	2.5 (7)	... (0)
Health care											
Life expectancy (in years)	68.1 (33)	63.3 (45)	57.6 (25)	0.4 (33)	0.2 (45)	0.2 (25)	0.1 (12)	-0.1 (13)	0.7 (4)	0.5 (9)	0.0 (16)
Infant mortality rate[3]	31.8 (34)	48.9 (48)	72.8 (25)	1.7 (34)	2.5 (48)	1.5 (25)	1.6 (13)	1.0 (14)	2.7 (5)	3.3 (10)	3.0 (16)
Under-5 mortality rate[3]	40.1 (29)	66.6 (29)	113.2 (14)	3.8 (29)	3.7 (29)	2.9 (14)	2.3 (8)	0.8 (8)	... (0)	3.2 (7)	5.7 (13)
Births attended by skilled staff	78.5 (25)	64.0 (37)	52.4 (18)	6.1 (25)	1.8 (37)	3.2 (18)	0.8 (10)	1.7 (9)	4.2 (10)	-0.1 (11)	-0.3 (4)
Contraceptive prevalence[5]	66.3 (4)	49.3 (14)	36.0 (5)	3.6 (4)	3.1 (14)	5.6 (5)	6.7 (3)	6.9 (3)	2.0 (5)	2.5 (5)	0.0 (1)
Access to health care	94.6 (16)	74.0 (13)	48.7 (3)	1.4 (16)	3.7 (13)	11.2 (3)	4.0 (4)	6.6 (5)	6.2 (2)	0.4 (4)	... (0)
Percent under 12 months immunized											
DPT vaccination	86.8 (33)	82.6 (61)	74.6 (29)	4.5 (33)	4.8 (61)	6.9 (29)	7.3 (16)	5.7 (15)	7.7 (10)	3.8 (15)	3.7 (16)
Measles vaccination	85.0 (33)	83.0 (60)	75.3 (28)	5.4 (33)	4.4 (60)	6.1 (28)	6.8 (15)	4.3 (14)	9.1 (10)	3.3 (15)	2.8 (16)
Other basic services											
Access to safe water	81.7 (27)	66.0 (41)	58.1 (19)	4.1 (27)	2.9 (41)	4.2 (19)	4.0 (12)	4.2 (12)	7.7 (8)	1.6 (14)	-3.5 (5)
Access to sanitation	73.9 (23)	57.6 (37)	41.6 (17)	2.6 (23)	4.4 (37)	6.7 (17)	3.2 (10)	2.7 (10)	14.2 (8)	3.5 (14)	-9.9 (3)

Sources: World Bank, World Development Indicators 1998 and 1999 database.

[1]Latest data available. Mostly refers to 1995-97. Except for life expectancy, which is in years, all the indicators refer to shares of the relevant population groups. See also Box 2.

[2]Nonprogram countries, shown for comparison, included: Angola, The Bahamas, Bahrain, Belize, Bhutan, Botswana, Colombia, Cyprus, Eritrea, Fiji, Grenada, I.R. of Iran, Kuwait, Lebanon, Malaysia, Maldives, Malta, Myanmar, Namibia, Netherlands Antilles, Oman, Paraguay, Qatar, Seychelles, Solomon Islands, South Africa, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Swaziland, Syrian Arab Republic, Tonga, Turkmenistan, and United Arab Emirates.

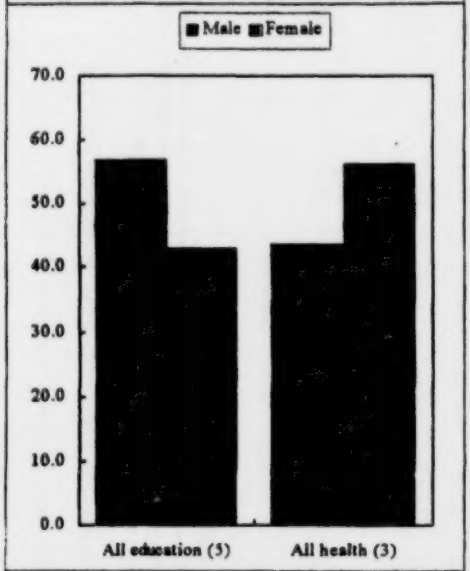
[3]The annual percent improvement in illiteracy, infant mortality, and under-5 mortality rates refers to a decline in these rates. An annual percent improvement of 3.4 in illiteracy, for example, means that illiteracy rates are falling by 3.4 percent per year.

[4]Gross enrollment rate is the ratio of total enrollment, regardless of age, to the population of the age group that corresponds to the level of education shown. If, for example due to grade repetition, students that fall outside the age bracket for primary or secondary education are nevertheless enrolled, the gross enrollment rate may exceed 100 percent.

[5]Contraceptive prevalence rate is the percentage of women who are practicing, or whose sexual partners are practicing, any form of contraception and is usually measured for women aged 15-49.

A/AC.253/16/Add.16

Figure 4. Benefit Incidence of Public Spending on Education and Health Care in IMF-Supported Program Countries (mid-1990s)



Source: Davoodi and Sachjapinan (forthcoming).

39. A pro-male bias in education spending is also discerned from limited data for five countries with IMF-supported programs (Figure 4), indicating that targeting of education spending needs to embody a gender dimension as well. By contrast, health care spending on average was higher for females in a sample of three countries. Some progress has been achieved in two countries (Ghana and Malawi), where the female share of benefits from public spending on education and health care has increased over time.

IV. Strengthening IMF's Contribution to Poverty Reduction

40. **As described in Section I, in late 1999 the IMF replaced the ESAF with the new Poverty Reduction and Growth Facility (PRGF) with the aim of making poverty reduction efforts in low-income members a key and more explicit element of a renewed growth-oriented economic strategy.** While recognizing that growth is a prerequisite for sustained poverty reduction, policies in the PRGF will be cognizant of the need to enable the poor to participate in, as well as contribute to the growth process, by increasing their capabilities and reducing vulnerabilities to risks. Thus, the targets and policies embodied in PRGF-supported programs (as well as all World Bank-supported programs) will emerge in each country directly from a Poverty Reduction Strategy Paper (PRSP) prepared by the government, with active participation of civil society including the poor, NGOs, donors and international institutions, including the UN. Such a participatory process will also enhance country ownership and accountability. The PRSP will ensure consistency between a country's macroeconomic, structural and social policies, and the goals of poverty reduction and social development.

41. **There are several other features, which will distinguish the PRSP from its precursor, the Policy Framework Paper (PFP), which was the basis for ESAF-supported programs.** The poverty reduction strategy will include clear, measurable, intermediate, and outcome-based indicators for the purpose of assessing progress in poverty reduction. Civil society will be involved in the monitoring of agreed-upon goals. The involvement of civil society will also be facilitated by the increased emphasis on improving governance and transparency in public sector management, which will serve to increase the efficiency and accountability of public spending. Macroeconomic policies will be better integrated with the social and sectoral policies and goals, to ensure that they are mutually supportive and consistent with the broader objective of promoting faster sustainable growth and reducing poverty. The impact of economic policies on poverty reduction objectives will be examined and budget costs of social and other relevant programs will be directly reflected in the targets and policies in the

PRSP. The integration of international development targets will also address some of the gender-related issues that can be both a cause and an effect of poverty. These goals aim to achieve universal education in all countries by 2015, make progress on gender equality by eliminating gender disparity in primary and secondary education by 2005, reduce maternal mortality rates by three-fourths and provide access to reproductive health services to all individuals of appropriate ages.

42. **The formulation of policies in PRSPs will be done by the authorities, through an interactive process of consultation with domestic and other stakeholders, MDBs, the UN, and bilateral donors, as well the World Bank and the IMF.** This process, as well as the implementation of policies, will involve a closer coordination with the relevant international institutions and agencies and bilateral donors. In the formulation of policies, key social and sectoral programs will be identified and prioritized under a participatory approach, and the impact on the budget will be costed and will be reflected in the design of the macroeconomic framework, including the level and composition of government expenditures and the fiscal and external deficits.

43. **The IMF and the World Bank will each take the lead role in their traditional areas in the process of assisting countries design and implement policies.** The staff of the IMF will not attempt to supplement or substitute for Bank work in poverty analysis or the development of social policies. This will help maximize the effective use of the two institutions' resources to support countries' adjustment and reform programs. Policies in the PRGF, underpinned by a country-led PRSP, developed in a participatory framework, will be the basis for lending operations as well as for the provision of debt relief in the World Bank and the IMF. The Boards of both the IMF and the World Bank will endorse the PRSP for these purposes. In this way, PRGF support will be consistent with the country's poverty reduction strategy.

44. The design and implementation of social sector policy issues in the new PRGF **will benefit from the strengthening in recent years in collaboration with the UN system**. The PRSP will also provide an opportunity to further strengthen the institutions' collaboration with governments in an agreed framework for poverty reduction. To this end, IMF, World Bank, and UNDP staffs have been engaged in discussions on how to respond to the new demands of PRSP and PRGF. The UNDP would be able to assist governments in building the capacity needed to implement and monitor the PRGF-supported programs. IMF and UNDP staffs met to consider how collaboration between the two institutions in several program countries in Africa and Latin America could be enhanced.

45. **To ensure that the IMF's ongoing support to countries includes elements of the new approach as quickly as possible, ongoing PRGF-supported programs would be based on an interim PRSP.** An interim PRSP will, inter alia, set out a timetable for the elaboration of a comprehensive PRSP in a participatory manner. In fact, many countries have already made substantial progress on the development of poverty reduction strategies, for example, see Boxes 2–4 on Bolivia, Mozambique, and Uganda.

Box 2. Bolivia: Progress on the Poverty Reduction Strategy (January 2000)

1. On the basis of a fully participatory national dialogue, Bolivian society will soon begin the process of developing a comprehensive poverty reduction strategy that could be implemented and monitored over a number of years. The authorities have already drafted an interim strategy paper. For this purpose, the starting point was the September 1997 Plan, together with a government-convened dialogue on national objectives and policies with the representatives of the business community, the Church, and labor and civil society organizations. The resulting agreements led to the Operational Plan of Action 1997–2002, based on four pillars, viz., opportunity, equity, dignity, and institutional reform. The poverty reduction strategy is based on this existing plan which will be reviewed and revised in the context of a renewed national dialogue to be held in early 2000.

2. The objectives of the dialogue will be: (i) to renew civil society trust and ownership; (ii) to prioritize the use of resources for poverty reduction; (iii) to establish a participatory body for monitoring; and most importantly, (iv) to transform government initiatives aimed at promoting growth and reducing poverty into local level initiatives, on the basis of agreements between the various stakeholders.

3. The interim strategy is expected to act as the framework for reopening the dialogue with civil society. The government views it, as a process in which there will be ample participation. It will also allow for the participatory process to monitor progress. The strategy proposes to coordinate the activities carried out under the opportunity, equity, and institutional pillars set in the 1997 Operative Plan of Action, Bolivia's commitments in the Paris Consultative Group, and any additional programs and actions needed to make poverty reduction feasible. The proposed interim plan sets out specific challenges for the short, medium, and long term with targets for economic growth, poverty reduction, and improved welfare.

4. A Steering Council is to be formed shortly to implement the dialogue, prepare social sector papers, conduct three regional workshops and review proposals. By May 2000, the National Dialogue Meetings would have provided full feedback to the Action Plan.

5. It is envisaged that the National Dialogue can be carried out over a relatively short time, leading to a final PRSP in May 2000.

Box 3. Mozambique: Progress on the Poverty Reduction Strategy (January 2000)

1. Mozambique has been contributing to poverty-reduction through the implementation of programs on education and health for a number of years. In 1995, the government introduced the Health Sector Recovery Program (HSRP), aimed at increasing access to health care and improving the quality of services through the rehabilitation and construction of primary health care facilities and rural hospitals. In 1998, the government developed an Education Sector Strategic Program (ESSP) in agreement with donors. The program aimed at achieving universal education coverage by the year 2010 as well as substantial quality improvements. A review of these programs was completed in 1999.

2. In April 1999, the government formulated a poverty action plan based on a poverty assessment completed in 1998. The plan is based on: (i) generating rapid, sustainable growth, particularly in rural areas; (ii) investing in human capital through improved delivery and quality of social services; and (iii) developing a program, including safety nets, that fosters the social and economic integration of the most vulnerable groups. In June 1999, implementation of the plan began with the definition of the procedures for integrating the plan into the budgetary processes.

3. Based on the progress achieved as of early 2000, the government is now preparing an interim poverty reduction strategy paper (PRSP). The government will subsequently prepare a full-fledged PRSP through a participatory process. The draft "Plano de Accao Quinquenal para a Reducao da Pobreza Absoluta" together with other key government papers such as the Five-Year Plan, the Medium-Term Expenditure Framework (MTEF), the Public Expenditure Survey (PES), the 2000 Budget, and the National Poverty Assessment provide a solid base for the production of the interim PRSP. The recently drafted "Plano de Accao" goes beyond the areas of health and education by bringing together a range of interrelated social sectors. The document also identifies a number of goals and targets for the next five years, some of which are in line with the International Development Targets (IDT) and presents some variables and indicators that would help to reach those goals and facilitate the monitoring process.

Box 4. Uganda: Progress on the Poverty Reduction Strategy (January 2000)

1. Uganda has made considerable progress on the design and implementation of a poverty reduction strategy under the ESAF (now PRGF) and under the HIPC Initiative.

2. In June 1997, Uganda launched a Poverty Eradication Action Plan (PEAP) following a national consultation process involving a broad cross-section of stakeholders (central and local government, civil society, and private sector). The strategy incorporates the results of the Uganda Participatory Poverty Assessment Project (UPPAP) and, inter alia, reflects the diagnostics of the nature of poverty in Uganda as well as some of the priority needs expressed by the poor, such as lack of access to security, to productive assets, and to services related to health and education.

3. In 1998/99, the government also adopted a medium-term budget framework (MTBF) under which the budget priorities are consistent with the PEAP. A transparent budget process with multiple channels of accountability is being developed which will strengthen monitoring arrangements. In addition, a Poverty Monitoring Unit will integrate annual household surveys conducted by the Uganda Bureau of Statistics with other data sources in order to ensure that policy is informed by poverty data and perceptions of the poor, on a timely and ongoing basis.

4. The staffs of the IMF and the Bank are of the view that many of the actions necessary for the implementation of an effective poverty reduction strategy are in place. The necessary actions remaining to prepare a comprehensive Poverty Reduction Strategy Paper (PRSP) are:

- Review and assess the appropriateness of the targeted quantitative outcomes, set out in the PEAP, in light of more recent information on the characteristics of poverty.
- Establish linkages between the targeted outcomes and intermediate output indicators under the direct control or influence of government policy.
- Establish, with as much precision as possible, the fiscal costs of achieving the targeted intermediate output indicators and ensure consistency between the fiscal costs of the poverty reduction strategy and macroeconomic stability.
- Conduct consultations with key stakeholders and clarify the role of civil society in monitoring outcomes.

A full-fledged PRSP for Uganda is expected later in the year 2000.